STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401-0070
(802) 657- 4220 OR 800-745-7371

APPLICATION FOR CERTIFICATION AS A PHYSICIAN ASSISTANT
INSTRUCTIONS AND CHECKLIST, PAGE ONE OF TWO

Thank you for your interest in physician assistant (PA) certification in Vermont.
Enclosed please find the application for certification. If you require an application status update, please telephone the office. It takes a minimum of six weeks to complete the process if there is nothing in the application requiring further Board review.
Any applicant with a disability who needs an accommodation should contact the Board office.
The following is a list of documents required (Unless noted, a copy of the original, if applicable—is required to be submitted):

1) ____ Fee of $100 if initial PA certification. Check made payable to Vermont to the Vermont Department of Health.

2) ___ Completed APPLICATION FOR CERTIFICATION AS A PHYSICIAN ASSISTANT IN VERMONT.

3) ___ Certified copy of Birth Certificate

4) ___ Copy of your employment contract. We have enclosed an employment contract form should you wish to use it.

5) ___ PRIMARY SUPERVISING PHYSICIAN APPLICATION must be completed by your primary physician and returned directly to this office. The Board may invite the supervising physician to an interview if the Board has not previously reviewed the system of care delivery in which you propose to practice.

6) ___ SECONDARY SUPERVISING PHYSICIAN APPLICATION from any secondary supervising physician(s).

7) ___ VERIFICATION OF PHYSICIAN ASSISTANT LICENSURE OR CERTIFICATION must be completed by the Licensing Board of each state where you now or have ever been allowed to practice as a physician's assistant. Copies of certifications or licenses are not accepted.

8) ___ For University trained applicants:
___A. A Certificate of Physician Assistant Education must be completed by your University.
___B. Proof of satisfactorily completing the certification examination given by NCCPA (National Commission on the Certification of Physician Assistants) from NCCPA. – To be sent directly to this office from the Examining Agency.

9) ___ For Vermont Apprenticeship trainined applicants:
___A. Documentation from the physician in charge of your Board-approved apprenticeship program that you have satisfactorily completed the program.
___B. Submit final PA trainee evaluation conducted by the Board to ensure that you are qualified by education, training and experience to perform the duties outlined in your scope of practice.

10) ___ Scope of Practice (See attached definition): A detailed description of the duties and scope of practice delegated to you by your supervising physician including authority to prescribe medications.

11) ___ Two (2) Completed Reference Forms mailed directly to the Board by the physician

12) ___ Personal Interview Required: As soon as your application is complete and the review process is finished, you will be provided with the name, address and telephone number of the Medical Board member you are to contact for a personal interview. (The Primary Supervising Physician also is interviewed by phone if he or she has never supervised a PA in Vermont.)

13) ___ Completed Form A if you answered "Yes" in Section III-IV.

14) ___ Your Signature Required:
- ___ 1) Photograph in Section IV;
- ___ 2) end of Section IV; and
- ___ 3) Form B: Notarized Release
- ___ 4) Certificate of Primary Supervising Physician
- ___ 5) Scope of Practice

15) ___ Please read the enclosed Board Statute and Rules and adopted AMA and AAPA recommendations for the working relationship between physicians and physician assistants.

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE

P.O. Box 70, Burlington, VT 05402
802-657-4220 or 800-745-7371

APPLICATION FOR CERTIFICATION AS A PHYSICIAN ASSISTANT IN VERMONT

I hearby apply for CERTIFICATION AS A PYSICIAN ASSISTANT in the state of Vermont

Part I

1. Name: _____
(Last) (First) (Middle)

2. Home Address: _____
(Street)

_____
(City) (State) (Zip)

3. Work Address: _____
(Street)

_____
(City) (State) (Zip)

4. Please check your preferred mailing address: ____ Home ____ Work

NOTE: ***The mailing address will be listed on the Board's web site.***

5. Have you ever legally changed your name? ___Yes ___ No If yes, enclose a certified copy of the document by which the name was changed.

6. Your name, as it should appear on your certificate: _____

7. Have you ever been licensed or certified in Vermont or elsewhere under another name? ___ yes ___ no
If yes, please complete the following.

_____
(Name) (Place) (License or Certificate)

8. Home Telephone Number: (_____) _____

9. Work Telephone Number: (_____) _____

10. E-mail address: _____

11. Date of Birth: Month:_____ Day _____ Year _____

12. Place of Birth:_____
Attach a certified copy of your birth certificate.

13. Social Security Number: _____

14. Certification Examination Taken – (Check the appropriate box and enter the date of examination):

____ (___/___/___) University Trained --NCCPA Examination

____ (___/___/___) Vermont Apprenticeship Trained

Education

15. List schools attended:

_____

(Name and Location of Institution) (From Month/Year to Month/Year) (Degree)

_____

(Name and Location of Institution) (From Month/Year to Month/Year) (Degree)

_____

(Name and Location of Institution) (From Month/Year to Month/Year) (Degree)

Supervising Physicians

16. List name and specialty of Primary Supervising Physician

_____

17. List name and specialty of Secondary Supervising Physician(s):

_____

_____

_____

Other Licenses and Certifications

18. Do you hold, or have you ever held, a license or certification as a medical practitioner in Vermont or any other state?
_____ Yes _____ No

If yes, complete the section below. Your application is not complete until we receive a Verification of Licensure or Certification from the licensing or certification authority in each case.

State Certificate/License Number Type of License/Certification Date Issued Status (Active or Inactive)

_____

_____

_____

19. Are you a graduate of a program accredited by the Committee on Allied Health Education and Accreditation (CAHEA) or its successor agency? _____ Yes _____ No

20. Do you hold a National Commission for the Certification of Physician Assistants (NCCPA) Certificate?
_____ Yes _____ No If yes, attach a copy.

NCCPA Certificate Number: _____ Expiration date: _____

21. When are you scheduled to begin work in Vermont?: _____

Training

22. List chronologically all formal medical training programs. Give program names, addresses, exact dates (month, day, year) and type of training. Include COPIES OF CERTIFICATES.

Program Name Address From/To Training

_____

_____

_____3.

List any other significant training:

_____

_____

24. Do you have now or have you previously had hospital privileges? _____ Yes _____ No

25. List all hospitals where you have, or previously have had, privileges:

NAME ADDRESS FROM/TO

_____

_____

26. What has been your physical residence(s) (city/state) in the past ten years?_____

_____

Part II

Any "yes" response to the questions below must be fully explained on the enclosed Form A.

27. Have you ever applied for and been denied a license or certificate to practice medicine or any other healing art?

_____Yes _____No

28. Have you ever withdrawn an application for a license or certificate to practice medicine or any other healing art?

_____Yes _____No

29. Have you ever voluntarily surrendered or resigned a license or certificate to practice medicine or any other healing art in lieu of disciplinary action?

_____Yes _____No

30. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?

_____Yes _____No

31. Have you ever been denied the privilege of taking an examination before any state medical examining board?

_____Yes _____No

32. Have you ever discontinued your education, training, or practice for a period of more than three months, for reasons other than a family situation?

_____Yes _____No

33. Have you ever been dismissed or suspended from, or asked to leave a training program before completion?

_____Yes _____No

34. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?

_____Yes _____No

35. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?

_____Yes _____No

36. Are you presently a defendant in a criminal proceeding?

_____Yes _____No

Confidential Section (The following section is exempt from public disclosure)

Any "yes" response to the questions below must be fully explained on the enclosed Form A.

37. To your knowledge, are you the subject of an investigation by any other licensing or certification board as of the date of this application?

_____Yes _____No

38. To your knowledge, are you presently the subject of criminal investigation?

_____Yes _____No

MEDICAL QUESTIONS

Please answer "**Yes**" or **"No**" to the questions below. Definitions are provided to assist you in answering. Please explain any "**Yes**" answers on Form A.

DEFINITIONS

In answering the following questions, please use these definitions:

"Ability to practice medicine" - This term includes:

1. The cognitive capacity to make and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks and procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" - Includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Currently" - This term means recently enough to have a real or perceived impact on one's functioning as an Anesthesiologist Assistant licensee.

"Chemical substances" - This term is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Controlled substances" - This term means those drugs listed on Schedules I through V of Section 202 of the Controlled Substances Act (21 USC § 812).

"Illegal use of controlled substances" - This term means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act, as periodically updated by the Food and Drug Administration. This term does not include the use of a drug taken under the supervision of a licensed health care professional or other uses authorized by the Controlled Substances Act or other provisions of federal law.

39. Do you have a medical condition that in any way impairs or limits your ability to practice medicine in your field of practice with reasonable skill and safety?

_____Yes _____No

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your medical condition is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

40. Are you currently engaged in the use of alcohol or other chemical substances that in any way impairs your ability to practice medicine in your field of practice with reasonable skill and safety?

_____Yes _____No

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your use is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

41. Are you currently engaged in the illegal use of controlled substances?

_____Yes _____No

In explaining a "Yes" answer on Form A, please provide reasonable assurances that such use is not a real and ongoing problem in your practice of medicine.

IMPORTANT

Since 1999, part of each physician license fee has been used to create and maintain the **Vermont Practitioners Health Program**, a **confidential** program for the identification, treatment and rehabilitation of practitioners affected by the disease of substance abuse. If you wish further information about this program, a service of the Vermont Medical Society, call 802-223-0400 (a confidential line).

Part III - Statutory Profile Questions

Vermont law, 26 VSA § 1368, creates a data repository within the Department of Health. Under this law, the Department must collect certain information to create individual profiles on all health care professionals licensed, certified,

or registered by the Department pursuant to Title 26 of the VSA. Please try to answer the following questions as best you can. You will receive a copy of your profile prior to its initial release to the public and each time the profile is modified or amended. You will be given a reasonable time to correct factual inaccuracies that appear in such profile. As noted below, certain questions do not need to be answered.

It is very important for us to receive copies of court papers, licensing and certification authority decisions, and other documents relevant to the questions below in order to have a true and accurate description of the actions taken.

42. **Criminal Convictions** [See 26 VSA § 1368(a)(1)]

Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted. For purposes of this question, "convicted" means that you pleaded guilty or that you were found or adjudged guilty by a court of competent jurisdiction. **Please provide copies of papers fully documenting the convictions.**

(Conviction Date)	(Court)	(City/State)	(Crime
(Conviction Date)	(Court)	(City/State)	(Crime)
(Conviction Date)	(Court)	(City/State)	(Crime)

43. **Nolo Contendere/Matters Continued** [See 26 VSA § 1368(a)(2)]

Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction. **Please provide copies of papers fully documenting these matters.**

(Conviction Date)	(Court)	(City/State)	(Charge)
(Conviction Date)	(Court)	(City/State)	(Charge)
(Conviction Date)	(Court)	(City/State)	(Charge)

44. **Vermont Board of Medical Practice Matters** [See 26 VSA § 1368(a)(3)]

Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipulations), and final disposition of such matters by the courts, if appealed.

(Date)	(Final Disposition - Summary)

45. **Licensing or Certification Authority Matters in Other States** [See 26 VSA § 1368(a)(4)]

Please provide a description of all formal charges served by licensing or certification authorities of other states, the findings, conclusions, and orders of such authorities, and final disposition of such matters by the courts, if appealed, in those states. **Please provide copies of papers fully documenting these matters.**

(Date of Final Disposition) (Licensing or Certification Authority) (Court) (City/State) (Nature of Charge)

(Date of Final Disposition) (Licensing or Certification Authority) (Court) (City/State) (Nature of Charge)

46. **Restriction of Hospital Privileges** [See 26 VSA § 1368(a)(5)]

A. **Revocation/Involuntary Restrictions**

Please provide a description of any revocation or involuntary restriction of your hospital privileges that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you. **Please provide copies of papers fully documenting these matters.**

(Date) (Hospital) (State) (Nature of Restriction) (Reason for Restriction)

(Date) (Hospital) (State) (Nature of Restriction) (Reason for Restriction)

B. **Other Restrictions**

Please provide a description of all resignations from, or non-renewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital. **Please provide copies of papers fully documenting these matters.**

(Date) (Hospital) (State)

(Nature of Action) (Action)

(Reason for Action) ☐ In lieu ☐ In settlement

47. **Medical Malpractice Court Judgments/Settlements** [See 26 VSA § 1368(a)(6A)]

A. **Judgments**

Please provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you in which a payment was awarded to a complaining party. **Please provide copies of papers fully documenting these matters.**

☐ Judgement ☐ Arbitration

(Date) (Court) (State) (Nature of Case) (Amount Assessed Against You)

☐ Judgement ☐ Arbitration

(Date) (Court) (State) (Nature of Case) (Amount Assessed Against You)

B. Settlements

Please provide a description of all settlements of medical malpractice claims against you in which a payment was awarded to a complaining party. **Please provide copies of papers fully documenting these matters.**

(Date) (Court) (State) (Amount of Settlement Against You)

(Date) (Court) (State) (Amount of Settlement Against You)

48. **Years of Practice** [See 26 VSA § 1368(a)(10)]

What month and year did you start practicing as a Physician Assistant?

49. **Hospital Privileges** [See 26 VSA § 1368(a)(11)]

List all hospitals where you currently have hospital staff privileges:

(Name) (City) (State) (Year Started)

(Name) (City) (State) (Year Started)

(Name) (City) (State) (Year Started)

50. **Appointments/Teaching** [See 26 VSA § 1368(a)(12)]

Note: Answering #50 is optional. By answering, you are granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

A. Appointments

Please provide information about your appointments to medical school or professional school faculties.

(School)	(City)	(State)	(Nature of Appointment)	From (year) To (year)
(School)	(City)	(State)	(Nature of Appointment)	From (year) To (year)

B. Teaching

Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years.

(School/Institution)	(City)	(State)	(Nature of Teaching)	From (year) To (year)

51. **Publications** [See 26 VSA § 1368(a)(13)]

Note: Answering #51 is optional. By answering, you are granting permission to have this information posted on the web.

Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years.

(Title)	(Publication)	(Year)
(Title)	(Publication)	(Year)

52. **Activities** [See 26 VSA § 1368(a)(14)]

Note: Answering #52 is optional. By answering, you are granting permission to have this information posted on the web.

Please provide information regarding your professional or community service activities and awards.

(Activities or Awards)

Part IV – Photograph and Signature

PROVIDE A PHOTOGRAPH: Attach a photograph below, taken within the last 60 days (head and shoulders). Proofs are not acceptable. Sign the front of the photograph. **Please do not use staples.**

Reminder - You must also complete the enclosed Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions.

I hereby aver that the information provided above is true and accurate, and that I have answered the questions to the best of my knowledge and ability.

Date:_____ _____

Applicant's Signature

-Vermont Department of Health - Board of Medical Practice
Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

Withdrawal or denial of license or certificate (Questions 27 and 28) - Attach documents

State_____ Year_____
Circumstances under which license or certificate was withdrawn, denied, revoked, not renewed, or otherwise terminated_____

_____

Voluntarily surrendered or resigned a license or certificate to practice medicine or any healing art (Question 29) - Attach documents

State_____ Year_____

Circumstances_____

_____

Disciplinary charges or action (Question 30) - Attach documents

Name of organization involved_____ Date_____

Duration_____

Action taken (circle all that apply)

01 Revocation of right or privilege
02 Suspension of right or privilege
03 Censure
04 Written reprimand or admonition
05 Restriction of right or privilege
06 Non-renewal of right or privilege
07 Fine
08 Required performance of public service
09 Education/Training/Counseling/Monitoring
10 Denial of rights or privilege
11 Resignation
12 Leave of absence
13 Withdrawal of an application
14 Termination or non-renewal of contract
15 Medical Records Suspension
16 Probation
17 Assurance of Discontinuance
18 Consent Agreement
19 Letter of Agreement
20 Expulsion from Membership
21 Reprimand
22 Other (specify)_____

Circumstances_____

_____

_____

Denial of examination privileges (Question 31) - Attach documents

State_____ Year_____

Circumstances under which examination privileges denied _____

_____

Training program(s) not completed - discontinued education, training, practice (Questions 32 and 33) - Attach documents

Training program(s) _____

Location of programs _____ Year _____

Circumstances_____

_____

Affecting health care institution staff privileges, employment or appointment (Question 34) - Attach documents

Institution involved _____

Location _____ Year _____

Circumstances_____

_____

Privilege to prescribe controlled substances (Question 35) - Attach documents

Name of organization involved _____

Type of restriction _____ Date _____

Circumstances of restriction

_____

_____

_____

_____

Criminal investigation - proceeding (Questions 36 and 38) - Attach documents

Court _____

City and state _____

Charge _____

Description _____

_____

_____

Status_____

_____

Conviction? _____ Yes _____ No Date _____

Plea? _____ Yes _____ No Date _____

Investigation by other licensing or certification board - proceeding (Question 37) - Attach documents

Date _____

Licensing or certification board _____

State _____

Description _____

_____

_____

Status_____

Medical condition, treatment, use of chemical or illegal substances (Questions 39-41)

Treating organization _____

Address _____Telephone _____

Type of diagnosis, condition or treatment - field of practice - use of chemical substances

_____

_____

Dates of illness of dependency _____ to _____

Dates of treatment _____ to _____

Name of rehabilitation/professional assistance or monitoring program _____

Address _____Telephone _____

Contact person at Program _____

(Question 47) Medical Malpractice Claim

Please provide the following information regarding each instance of alleged malpractice. This section should be photo copied and filled out separately for each claim. Additional sheets may be obtained/used if necessary.

Insurer_____

Claimant name _____

Description of alleged claim (allegations only): This does not constitute an admission of fault or liability.

Please indicate:
1. Patient's condition at point of your involvement;
2. Patient's condition at end of treatment;
3. The nature and extent of your involvement with the patient;
4. Your degree of responsibility for the course of treatment in leading to the claim; and
5. Narrative of event.

_____

_____

_____

_____

If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

_____

Your role (circle one):

01 Anesthesiologist	11 PGY 4
02 Primary Care Physician	12 PGY 5
03 Referring Physician	13 PGY 6
04 Attending Physician	14 PGY 7
05 Consultant Specialist	15 Workmen's Compensation Evaluator
06 Surgeon	16 Court Psychiatrist
07 Fellow	17 On-Call Physician
08 PGY 1	18 Group Practitioner/Partner
09 PGY 2	19 Other: Specify _____
10 PGY 3	20 Unknown

Your Legal Representative in this matter (include name, address and telephone number)

Name _____

Firm _____

Address _____

City, State, Zip _____

Phone _____

Indicate Decision, Appeal, Settlement, Dismissal:

If a Court or Arbitration Panel heard your case, indicate the following:

Court_____

Court's location_____

Docket number_____

Date the action was filed_____

Decision determined by (check one): _____ Judge _____ Jury _____ Arbitration Panel

Decision: _____ Award: _____

If your case was appealed, indicate the following: Date appeal filed (month, day, year)
_____/_____/_____
Date appeal decided: (month, day, year) _____/_____/_____

If your case was settled, indicate the following:

Settlement amount paid on your behalf: _____

Total settlement amount: _____

Date of settlement: (month, day, year) _____/_____/_____

_____ Case dismissed against you _____ Against all defendants

Important: In addition to the above information, please attach a copy of the complaint and final judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.

Additional information, if any:

_____

_____

_____

Vermont Department of Health - Board of Medical Practice

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS

You must answer questions 1, 2, and 3.

Regarding Child Support

Title 15 § 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed. "Good standing" means that less than one-twelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved by the office of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would impose an unreasonable hardship. (15 V.S.A. § 795)

1. You must check one of the two statements below regarding child support regardless whether or not you have children:

- ❑ I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.

or

- ❑ I hereby certify that I am NOT in good standing with respect to child support dues as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Taxes

Title 32 § 3113 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with the Department of Taxes. "Good standing" means that no taxes are due and payable and all returns have been filed, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)

2. You must check one of the two statements below regarding taxes:

- ❑ I hereby certify, under the pains and penalties or perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a $10,000.00 fine or both).

or

- ❑ I hereby certify that I am NOT in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Unemployment Compensation Contributions

Title 21 § 1378 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business (including a license to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate space with any employing unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the employing unit is in good standing with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of contributions due as of the date such declaration is made. For the purposes of this section, a person is in good standing with respect to any and all contributions or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) the liability for any contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a payment plan approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions or payments in lieu of contributions due and payable would impose an unreasonable hardship.

3. You must check one of the three statements below regarding unemployment contributions or payments in lieu of unemployment contributions:

- ❑ I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a payment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or payments in lieu of unemployment contributions to the Vermont Department of Employment and Training due as of the date of this application. (The maximum penalty for perjury is 15 years in prison, a $10, 000.00 fine or both.)

or

- ❑ I hereby certify that I am NOT in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.

or

- ❑ I hereby certify that 21 V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.

Social Security #* _____/_____/_____ Date of Birth _____/_____/

* The disclosure of your social security number is mandatory, it is solicited by the authority granted by 42 U.S.C. § 405 (c)(2)(C), and will be used by the Department of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected by such laws, and by the Office of Child Support.

STATEMENT OF APPLICANT

I certify that the information stated by me in this application is true and accurate to the best of my knowledge and that I understand providing false information or omission of information is unlawful and may jeopardize my license/certification/registration status.

Signature of Applicant_____ Date_____

FORM B

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401-0070
(802) 657- 4220

FORM B: 1) AUTHORIZATION FOR RELEASE OF RECORDS AND INFORMATION AND 2) AUTHORIZATION TO COMMUNICATE WITH FUTURE EMPLOYERS REGARDING THE STATUS IF YOUR APPLICATION

TO WHOM IT MAY CONCERN:

I, _____ HEREBY AUTHORIZE YOU to furnish to
(Name of Applicant)

the Vermont Board of Medical Practice or its designated representative, all materials and information within your possession or control relating to me, of whatever kind and wherever located and including, but not limited to, my professional experience and qualifications, my licensing history, my practice as a physician assistant, and any other material or information, including investigative files, which, in the sole discretion of the Vermont Board of Medical Practice, may be useful to said Board in its review of my licensing status.

Only in regard to this specific authorization for disclosure to the Vermont Board of Medical Practice and for no other purpose, I expressly WAIVE confidentiality and any privileges or immunities accorded this information by State or Federal Law, and I hold you harmless from disclosure of same to the Vermont Board of Medical Practice.

YOU ARE ALSO AUTHORIZED to report information, either orally or in writing, directly to the Vermont Board of Medical Practice or its designated representative on a continuing basis until this authorization is revoked, by me, in writing.

A CONFORMED PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL SERVE IN ITS STEAD.

2) I further authorize the Vermont Board of Medical Practice to communicate with future employers and/or locum tenens companies regarding the status of my application for certification.

Signature: _____

Date: _____

Print or Type Name: _____

Address: _____

City, State, Zip Code: _____

Telephone Number: (_____)_____

Subscribed and sworn to before me, this_____day of _____

_____
Notary Public

A CONFORMED COPY, ATTEST _____
Notary Public

RETURN ORIGINAL TO THE BOARD WITH YOUR APPLICATION
SEND COPIES WITH THE REFERENCE FORMS

EMPLOYMENT CONTRACT

I, _____ , an applicant for
(Applicant's Name)

Certification as a Physician Assistant, am employed by

_____
(Employer's Name)

for the period beginning _____
(Month/Day/Year)

Termination of my contract will cause my Certification to become null and void.

_____ _____
Signature of Physician Assistant (Date)

_____ _____
Signature of Supervising Physician (Date)

Print Name of Physician _____

NOTE: A contract from each separate employer is required.

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VT 05401
(802) 657-4220

PRIMARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed.

Name in full _____
(Last) (First) (Middle)

Mailing Address _____
(Office Name)

_____
(Street)

_____
(City/State) (Zip Code) (Telephone Number)

Vermont License #: _____

Hospital(s) where you have privileges: Hospital(s) Location Specialty

_____

_____

_____

What arrangements have you made for supervision when you are not available or out of town:

_____

_____

CERTIFICATE OF SUPERVISING PHYSICIAN

I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of _____, P.A. while under my supervision. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice. I further certify that notice will be posted that a physician's assistant is used, in accordance with 26 VSA, Chapter 31, Section 1741.

I further certify that I have read the statutes and Board rules governing physician assistants.

_____ _____
(Date) (Signature of Supervising Physician)

Co-signature of PA: _____

Note: A PA who prescribes controlled drugs must obtain an ID number from DEA. PA's DEA Number _____

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VT 05401
(802) 657-4220

SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed.

Name in full _____
(Last) (First) (Middle)

Mailing Address _____
(Office Name)

_____
(Street)

_____
(City/State) (Zip Code) (Telephone Number)

Vermont License #: _____

Hospital(s) where you have privileges: Hospital(s) Location Specialty

_____

_____

_____

List all physician's assistants names and addresses you currently supervise:

_____

_____

_____

CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN

I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of _____, P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician's Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice andthat in accordance with 26 VSA, Chapter 31, Section 1741, the use of a physician's assistant has been posted.

I further certify that I have read the statutes and Board rules governing physician assistants.

_____ _____
(Date) (Signature of Secondary Supervising Physician)

3.1.11 AUTHORITY TO PRESCRIBE DRUGS

The certified physician's assistant may prescribe only those drugs utilized by the primary supervising physician and permitted by the scope of practice submitted to and approved by the Board.

The drug order shall be signed, "(physician assistant's name) for (physician's name)".

Upon a pharmacist's request, the Board shall furnish a copy of the Board approved scope of practice and a signature sample of the physician's assistant.

3.1.12 PRIMARY SUPERVISING PHYSICIAN

The supervising physician shall:

1. be qualified to practice medicine in the field(s) of medicine in which he or she actively practices;
2. supervise physician assistants only in the field(s) of medicine in which he or she actively practices;
3. submit his or her usual scope of practice as defined in 3.1.1, 10 a).
4. outline in detail how he or she will be available for consultation and review of work performed by the physician's assistant;
5. supervise no more physician assistants concurrently than have been approved by the Board after review of the system of care delivery;
6. furnish copies of the physician assistant's scope of practice to any medical facilities with which the physician's assistant is affiliated or employed;
7. conduct and document regular chart reviews, such as chart audits, and retrospective patient care audits, or review and countersign PA notes;
8. immediately notify the Board in writing of dissolution of the physician assistant's employment contract and the reason(s) for dissolution. Similar notification is required if the scope of practice changes, the employer(s) change, or there is a change in the primary or secondary supervising physician(s). Board approval must be received, otherwise the PA's certificate becomes void. Documents already on file with the Board need not be resubmitted.
9. sign a statement certifying that the primary supervising physician has read the statutes and Board rules governing physician assistants.

3.1.13 SECONDARY SUPERVISING PHYSICIAN

The secondary supervising physician shall:

1. be qualified to practice in the field(s) of medicine in which the physician assistant is practicing;
2. supervise physician assistants only in the field(s) of medicine in which he or she actively practices;
3. be responsible for the physician assistant's medical acts only when consulted by the physician assistant.
4. be available for consultation as secondary supervising physician;
5. have read and signed the scope of practice submitted to and approved by the Board;
6. supervise no more physician assistants concurrently than have been approved by the Board after review of the system of care delivery;
7. immediately notify the Board of dissolution of secondary supervision and reasons for dissolution of the physician assistant employment contract. The notification shall include the reasons for ending the employment relationship if any of the grounds of unprofessional conduct as described in 26 V.S.A. Section 1736 has occurred.;
8. sign a statement certifying that the secondary supervising physician has read the statutes and Board rules governing physician assistants.

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401-0070
(802) 657- 4220

VERIFICATION OF PHYSICIAN ASSISTANT LICENSURE OR CERTIFICATION

This section must be completed by the regulatory authority in the states in which **you now hold or have ever held** a license or certification to practice as a physician's assistant.

I, _____ Secretary of the _____

State Board of _____, certify that

_____ was granted Certificate Number _____

to practice as a physician's assistant in the State of _____

on the _____ day of _____ 19 _____

and that said certificate has never been revoked, suspended or conditioned in any way, or the licensee has never been disciplined by the Board in any way.

NOTE: If licensed by written examination the secretary should further certify:

I further certify that the aforesaid _____ in his/her written

Examination before this Board, obtained a general average of _____ percent in the

Following branches:

(The subjects of the examination and rating of each must be stated in full.)

_____

_____

_____

(AFFIX SEAL) _____ _____
(Secretary/Director) (Date)

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401
(802) 657- 4220

CERTIFICATE OF PHYSICIAN ASSISTANT EDUCATION

I hereby certify that, _____ was admitted to the
(Name)

_____ Physician Assistant

Program in _____ on _____
(City and State) (Date)

and completed all requirements for graduation on _____.
(Date)

A _____ was granted on _____
(Specify certificate/diploma/degree) (Date)

Is this program CAHEA or successor agency approved? _____ Yes _____ No

(AFFIX SEAL)

Date: _____

Signed: _____
(Authorized Officer of the School)

TO PROGRAM: Return to above address

VERMONT BOARD OF MEDICAL PRACTICE
PHYSICIAN ASSISTANT SCOPE OF PRACTICE

"Scope of practice" means a written document detailing those areas of medical practice including duties and medical acts, delegated to the physician assistant by the supervising physician for which the licensee is qualified by education, training and experience. At no time shall the scope of practice of the physician assistant exceed the normal scope of either the primary or secondary supervising physician(s)' practice.

Physician assistants practice medicine with physician supervision. Physician assistants may perform those duties and responsibilities, including the prescribing and dispensing of drugs and medical devices, that are delegated by their supervising physician(s).

Physician assistants shall be considered the agents of their supervising physicians in the performance of all practice-related activities, including but not limited to. the ordering of diagnostic, therapeutic and other medical services.

It is the obligation of each team of physician(s) and the physician assistant(s) to insure that the written scope of practice submitted to the Board for approval clearly delineates the role of the physician assistant in the medical practice of the supervising physician. This should cover at least the following categories:

a) Narrative: A brief description of the practice setting, the types of patients and patient encounters common to this practice and a general overview of the role of the physician assistant in that practice.

b) Supervision: A detailed explanation of the mechanisms for on-site and off-site physician supervision and communication, back-up and secondary supervising physician utilization. Included here should be a description of the method of transport and back-up procedures for immediate care and transport of patients who are in need of emergency care when the supervising physician is not on premises. This explanation should include issues such as, ongoing review of the physician assistant's activities. retrospective chart review, co-signing of patient charts, and utilization of the services of non-supervising physicians and consultants.

c) Sites of Practice: A description of any and all practice sites (i.e. office, clinic, hospital outpatient, hospital inpatient, industrial sites, schools, etc.). For each site, a description of the PA's activities.

d) Tasks/Duties: A list of the PA's tasks and duties in the supervising physician's scope of practice.

This list should express a sense of involvement in the level of medical care in that practice. The supervising, physician may only delegate those tasks for which the physician assistant is qualified by education, training and experience to perform. Notwithstanding the above, the physician assistant should initiate emergency care when required while accessing back-up assistance. At no time should a particular task assigned to the-PA fall outside of the scope of practice of the supervising physician.

e) An authorization to prescribe medications which includes the following statements:

1) The physician assistant named in this document will be authorized to prescribe medications in, accordance with the scope of practice submitted to and approved by the Vermont Board of Medical Practice.,

2) The physician assistant named in this document will be authorized to prescribe controlled drugs in accordance with the scope of practice submitted to and approved by the Vermont Board of Medical Practice. A physician assistant who prescribes controlled drugs must obtain an identification number from the federal Drug Enforcement Agency (DEA). The physician assistant DEA number is (insert DEA number).

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401-0070
(802) 657- 4220

LIST OF TWO REFERENCES

The Board rules require that references be from allopathic or osteopathic physicians with whom the applicant has worked recently, including one from the most recent primary supervisor. If the applicant has recently graduated from a Board-approved physician assistant program, one must be from the Director of the program. If the applicant has recently completed a Board-approved apprenticeship program, one must be from the primary training physician.

Detach the attached Reference Forms and send to the individuals designated below ALONG WITH A COPY OF THE SIGNED FORM B RELEASE. Return this sheet to the Board with your application. Individuals completing the reference forms must return the forms directly to the Board.

Names, addresses and telephone numbers of two references:

1) Reference #1 – Name of a Physician: _____

Address: _____

_____

City, State, Zip Code: _____

Telephone: (_____) _____

How long has this individual known you? _____

2) Reference #2 – Name of a Physician: _____

Address: _____

_____

City, State, Zip Code: _____

Telephone: (_____) _____

How long has this individual known you? _____

Reference Form #1 Return Directly to the Board

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401-0070
(802) 657- 4220

Name of applicant: _____
The physician assistant named above has applied to the Vermont Board of Medical Practice for a certification to practice as a physician assistant in Vermont. The applicant has listed your name as one who has requisite knowledge through recent observation of the applicant's current clinical competence, ethical character, and ability to work cooperatively with others. In this regard, please complete the following reference form. Thank you for your cooperation.

Please complete all parts of this form. If more room is needed, please attach additional information.

Name _____was at _____

From _____to _____. During that time, he/she

Was (List status in the institution): _____

IMPORTANT NOTE: If you rate the applicant "poor" or "fair" in a particular category, please elaborate on this aspect of the reference in as much detail as possible.

The basic medical knowledge to be expected in a PA:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Professional judgement:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Sense of responsibility:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Moral character/ethical conduct:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Competence and skills in the tasks delegated:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Cooperativeness ability to work with others:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Willingness to accept directions and limitations in role:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
History & physical exam:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Record keeping:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
P.A.-Patient relationship:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Track record in adhering to scope of practice:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Ability to communicate in reading, writing and speaking the English language:	_____ Poor	_____ Fair	_____ Average	_____ Above Average

Return Directly to the Board

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401-0070
(802) 657- 4220

REFERENCE FORM TO BE COMPLETED BY PHYSICIAN WORKED WITH MOST RECENTLY
PAGE TWO OF TWO

Name of applicant: _____

To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner?	____Yes	____ No
Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice as a physician's assistant?	____Yes	____ No
Do you know of any pending professional misconduct proceedings or medical malpractice claims?	____Yes	____ No
Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses?	____Yes	____ No
Do you know of any suspension, restriction or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice?	____Yes	____ No
Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures?	____Yes	____ No
Do you know of any confirmed quality concern (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere?	____Yes	____ No
Do you know of a failure of the applicant to complete a training program(s)?	____Yes	____ No
Does the applicant call upon consults when needed?	____Yes	____ No

In addition to the information provided on the previous page, please use the space below and the reverse side for elaboration on the above and any additional information you have available to aid the Board in evaluating this applicant. Of particular value to us in evaluating any applicant are comments regarding his/her notable strengths and/or weaknesses. We would appreciate such comments from you. Any additional information should be attached to this form.

The above report is based on:

_____ Close personal observation
_____ General impression
_____ A composite of previous evaluations
_____ Other – Specify: _____

I further certify that at the time of completion of the above training, or during my association with the physician assistant, he/she was competent to practice as a physician assistant and he/she was not the subject of any disciplinary action.

I recommend _____ for licensure in Vermont.

Signed: _____ Date: _____

Print or Type Name and Title: _____

Reference Form #2 Return Directly to the Board

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401-0070
(802) 657- 4220

Name of applicant: _____
The physician assistant named above has applied to the Vermont Board of Medical Practice for a certification to practice as a physician assistant in Vermont. The applicant has listed your name as one who has requisite knowledge through recent observation of the applicant's current clinical competence, ethical character, and ability to work cooperatively with others. In this regard, please complete the following reference form. Thank you for your cooperation.

Please complete all parts of this form. If more room is needed, please attach additional information.

Name _____ was at _____

From _____ to _____. During that time, he/she

Was (List status in the institution): _____

IMPORTANT NOTE: If you rate the applicant "poor" or "fair" in a particular category, please elaborate on this aspect of the reference in as much detail as possible.

The basic medical knowledge to be expected in a PA:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Professional judgement:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Sense of responsibility:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Moral character/ethical conduct:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Competence and skills in the tasks delegated:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Cooperativeness ability to work with others:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Willingness to accept directions and limitations in role:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
History & physical exam:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Record keeping:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
P.A.-Patient relationship:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Track record in adhering to scope of practice:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Ability to communicate in reading, writing and speaking the English language:	_____ Poor	_____ Fair	_____ Average	_____ Above Average

Return Directly to the Board

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401-0070
(802) 657- 4220

REFERENCE FORM TO BE COMPLETED BY PHYSICIAN WORKED WITH MOST RECENTLY
PAGE TWO OF TWO

Name of applicant: _____

To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner?	____Yes	____ No
Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice as a physician's assistant?	____Yes	____ No
Do you know of any pending professional misconduct proceedings or medical malpractice claims?	____Yes	____ No
Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses?	____Yes	____ No
Do you know of any suspension, restriction or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice?	____Yes	____ No
Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures?	____Yes	____ No
Do you know of any confirmed quality concern (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere?	____Yes	____ No
Do you know of a failure of the applicant to complete a training program(s)?	____Yes	____ No
Does the applicant call upon consults when needed?	____Yes	____ No

In addition to the information provided on the previous page, please use the space below and the reverse side for elaboration on the above and any additional information you have available to aid the Board in evaluating this applicant. Of particular value to us in evaluating any applicant are comments regarding his/her notable strengths and/or weaknesses. We would appreciate such comments from you. Any additional information should be attached to this form.

The above report is based on:

_____ Close personal observation
_____ General impression
_____ A composite of previous evaluations
_____ Other – Specify: _____

I further certify that at the time of completion of the above training, or during my association with the physician assistant, he/she was competent to practice as a physician assistant and he/she was not the subject of any disciplinary action.

I recommend _____ for licensure in Vermont.

Signed: _____ Date: _____

Print or Type Name and Title: _____

VERMONT BOARD OF MEDICAL PRACTICE

At its meeting on June 5, 1996, the Vermont Board of Medical Practice adopted the American Medical Association (AMA) and American Academy of Physician Assistants (AAPA) recommendations for the working relationship between physicians and physician assistants.

1. The physician is responsible for managing the health care of patients in all practice settings.

2. Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice as defined by state law.

3. The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.

4. The physician is responsible for the supervision of the physician assistant in all settings.

5. The role of the physician assistant(s) in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.

6. The physician must be available for consultation with the physician assistant at all times either in person or through telecommunication systems or other means.

7. The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training and experience and preparation of the physician assistant as adjudged by the physician.

8. Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.

9. The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.

10. The physician is responsible for clarifying and familiarizing the physician assistant with [her] his supervising methods and style of delegating patient care.

AMA House of Delegates, June 1995